

## Compassion and Care

Perspectives from an Indian origin psychologist working in Danish Academia & Mental Health Services

Singla, Rashmi

*Publication date:*  
2013

*Document Version*  
Early version, also known as pre-print

*Citation for published version (APA):*

Singla, R. (2013, Oct 24). Compassion and Care: Perspectives from an Indian origin psychologist working in Danish Academia & Mental Health Services. <http://www.careif.org>

### General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain.
- You may freely distribute the URL identifying the publication in the public portal.

### Take down policy

If you believe that this document breaches copyright please contact [rucforsk@kb.dk](mailto:rucforsk@kb.dk) providing details, and we will remove access to the work immediately and investigate your claim.



Centre for **A**pplied **R**esearch & **E**valuation  
**I**nternational **F**oundation

National Office:  
The Centre for Psychiatry,  
Barts and The London School of Medicine and Dentistry  
Queen Mary University of London  
Old Anatomy Building  
Charterhouse Square  
London EC1M 6BQ

Tel 020 7882 2021

Fax 020 7882 5728

Email: [enquiries@careif.org](mailto:enquiries@careif.org)

Website: <http://www.careif.org>

Twitter [@careif](https://twitter.com/careif)

October 2013

## *In Conversation with Compassion and Care.*

Recent events have questioned our humanity towards the most vulnerable in society; The reporting, discussions and increasingly the direction has revolved around Compassion and Care which bring into sharp focus the value base, characteristics and culture of individuals and the state. We – careif- asked and received an overwhelming global response from our friends, supporters and the public of their testimonies of what Compassion and Care is and meant to them. Here we publish the first set in a series of what people want to say, in their words and in their style.

One of our guiding principles of how we operate careif, is to believe and practice that if you share knowledge you change lives; we add these narratives to the reservoir that has gone so far.

All the people involved with careif, Trustees, International Advisors, Patrons, Friends, Supporters, etc give their time as volunteers. If you want to be part of this careif experience or indeed contribute your own testimony on Compassion and Care; **email us at** [enquiries@careif.org](mailto:enquiries@careif.org)

**Albert.Persaud Co-Founder & Director.**

---

**share knowledge change lives**

Centre for Applied Research & Evaluation International Foundation.

[www.careif.org](http://www.careif.org) Twitter @careif email [enquiries@careif.org](mailto:enquiries@careif.org)

### COMPASSION AND CARE:

Jisraj Singh Gataora: **Abilities Champion. UK**

*"I am much better than before, due to reason of me having such a family, who would help me intensively, if it wasn't for them, in my opinion, my care would not be as successful as it was/is".*

These two words – *Compassion* and *Care*- seem to be appearing in the press frequently. Therefore what do they mean individually? The free online dictionary <http://www.thefreedictionary.com/compassion> defines "Compassion" as 'Deep awareness of the suffering of another, coupled with the wish to relieve it'.

<http://medicaldictionary.thefreedictionary.com/CARE> defines "Care" as 'the services rendered by members of the health professions for the benefit of a patient.'

When thinking of compassion and care, usually the attention goes to the caring role played by agencies created especially to provide services for persons deemed to be vulnerable due to ill-health, age, disability, etc., for example the National Health Service (NHS). The NHS was created to provide a system which provides a free health care service to everyone, irrespective of their income, class and ability to pay; which ensures members of the public receives free medical advice and treatment if needed. This service is paid for in general by taxation.

A standard of care in hospitals ought to mean delivering care for patients of any age, who have been admitted. However in majority of cases, for example the elderly, are at risk of not receiving as good care as is expected to enhance their quality of life. It has been well documented that due to feeling out of control, powerless, having to rely on others for basic care the vulnerable group, for whom the caring services were created in the first place are unable to have a voice to complain. This is not to say that all vulnerable people are ill-treated but there are pockets of care that is failing the elderly who had done everything in their youth to ensure their old age is happy and comfortable. However, when the unexpected such as ill health strikes, it has been observed that some caring staff fail to deliver the service that they are employed for i.e. care with respect. Therefore it is these few that give the caring agencies a bad reputation and most important distressing experience to others whom they see as powerless and vulnerable.

---

**share knowledge change lives**

There are examples where the service fails to deliver the basics and lacks compassion and care. An example is reported at. <http://www.ombudsman.org.uk/care-and-compassion/case-studies/mrs-as-story2> Mr and Mrs J's Story. Mrs J, 82 years old, suffering from Alzheimer's was rushed to hospital with breathing problems. She was admitted to A&E and assessed on arrival by a Senior House Officer who asked Mr J to wait in a waiting room. The Staff attended to Mrs J but she sadly died and they forgot to tell Mr J that his wife had passed away. He could not be with his wife in her last moments. It appears the staff members went about their business without having any awareness of the Mr. J.'s distress and trauma.

Also an Indian nurse who was taking care of the Duchess of Cambridge, while pregnant was subjected to a prank call, the consequences of which had a tragic end. Before taking her own life the victim—Jacintha had commented on how humiliating the whole ordeal was. <http://www.ajustnhs.com/case-histories-of-victimised-nhs-staff/>

The General Practitioner, Dr Harold Shipman, who betrayed his patients trust in him by administering lethal doses of drugs to the most vulnerable and then himself, - committed suicide in 2004. <http://www.dailymail.co.uk/news/article-335607/Killer-Shipman-murdered-250-patients.html>

The NHS would seem to be in crisis due to the funding cuts and the continual reduction of key staff members. The reduction in staff members and having to work long hours, tiredness in staff members takes a toll and that could be the reasons behind their behaviour being negligent towards patients. A vast amount of staff members are also victimised due to the hierarchy of professionals who see themselves as powerful and beyond the law and take on a 'God' role for their own gratification.

In my experience I have been, on the whole, been well cared for after my Road Traffic Accident, (RTA) I had in 2004. However, I wonder, had my family not been so vigilant regarding my care and treatment would the outcome of my recovery been as positive as it is now. I had no recollection of the incidents due to my severe brain injury, but have learnt about the heavy handed and what we would call negligent care by some nurses. However I would like to say the majority of the nurses were very caring and had a great deal of compassion to deliver a safe and positive care. In fact it was these brilliant, what we as a family, would say 'angels' that were also vigilant and had alerted and administered immediate action to rectify their colleagues carelessness. I am much better than before due to reason of me having such a family who would help me intensively, if it wasn't for them, in my opinion, my care would not be as successful as it was/is.

Although it can be argued that patients should not have to depend on their family for the quality of their care, the reality is very different as in the absence of family's vigilance the

---

**share knowledge change lives**

outcome for patients, who are already vulnerable due to their ill health, would be disastrous. For example, there were other patients on the wards that were not as lucky. We observed the helplessness of the elderly gentleman who due to his age was not able to feed himself and although half-hearted effort was made to help him, food was usually left in front of him and then taken away. Therefore, although family is very important to support and play a big part in their loved one's recovery, they should not have the added pressure of responsibility to oversee safe care as well as, cope with the trauma and loss of their circumstances.

Personally, in my opinion, hospitals and caring professionals should take responsibility for monitoring and over viewing the care given by providing ongoing education and training for all medical staff. It is no more than common sense that all medical staff and other staff delivering caring services should be supported by providing a space for them to be able to talk of their distress/stress in a more structured setting. They are at the forefront of delivering services and see a lot of distress, trauma and loss. Therefore if the nurses and other medical staff are expected to help, have empathy and comfort towards patients, their employers should also be delivering the same to them, a sort of positive role modelling. It is important that safe, supportive practice is not ignored due to the cost issue as human life is much more costly.

The NHS had to pay out up to £2.8bn in compensation for acts of medical negligence in hospitals towards patients (<http://news.bbc.co.uk/1/hi/health/337327.stm>), Last November, a severely disabled girl set a new record when she was awarded £3.9m in compensation for brain damage that occurred during routine surgery. The cost of compensation is astonishingly increasing, which is a huge problem. However, compensation, I feel, does not replace or compensate for the loss of persons to these incidents.

In conclusion to this article, the NHS is evidently in major crises due to the demands on delivering high quality care to the vulnerable people in society that come through their doors. They have a responsibility to provide not only education but also support services for their employees to ensure safe practice which does not leave a patient feeling neglected and at risk.

**Jisraj Singh Gataora: Abilities Champion. UK**

---

**share knowledge change lives**

Centre for Applied Research & Evaluation International Foundation.

[www.careif.org](http://www.careif.org) Twitter @careif email [enquiries@careif.org](mailto:enquiries@careif.org)

## Compassion and Care:

**Michelle Younger: Chair of careif and Senior Project Worker in London at the Children's Society: UK.**

*“a professional value base that speaks of love and compassion, for all those working with young people, could go a long way to changing attitudes and creating a healthier society”.*

Compassion to me is showing love and kindness without judgement, working to understand and meet the needs of whoever you are working with, being willing to listen, change your approach and fight their corner whenever you need to, because you care about the outcome and the impact of change on a person's life. Working with young people can feel like a constant battle to change attitudes, to help people to understand, that young people have a right to an opinion and to express that opinion and their identity however they chose to. The Dalai Lama speaks of compassion as, “understanding a person's suffering and being able to place yourself in their shoes to foster a desire to help relieve it”. I like the idea of this approach which relates closely to forgiveness and being able to forgive people who do wrong by you but considering their own experiences.

In my experience a lot of young people have been interested in why youth workers and participation workers do their jobs; they want to see that the people who support them care about them and care about their jobs, that it's not just a job. I have spoken to young people with personal support needs who want people to take care of them, who they trust and who can show that they care about them; it's not just a job, it's an attitude and an approach to everything you do. I find it difficult to believe that you can teach people to care; I feel that you either do or you don't but I do know that experience changes attitudes and so I have to believe, that everyone has the capacity to change, including being compassionate and caring. I think

---

**share knowledge change lives**

that you can still fulfil your job role and have a positive impact on young people if you do the job properly, but it is those who really care who will go that extra mile and have lasting and meaningful relationships with young people to enhance their lives and their opportunities to grow and learn.

Recently I heard a story of a disabled young person who went to a group for respite care; this is where the parents get a chance to have some time without caring responsibilities safe in the knowledge that their son or daughter is being cared for. The young person on a number of occasions came home with their hearing aid turned off, despite many requests to staff and managers along with clear instructions about how the hearing aid operates. The young person has a right to hear, the same as anyone else and an organisation operating with compassion should understand that a young person might feel if their hearing aid is turned off, they would imagine and feel isolated and excluded. The same young person attends a voluntary, universal, uniformed group where they are assigned a 'helper' for the evening to ensure they can participate; with the leader of the group organising all of the young person's personal care needs. The people in this organisation go out of their way to make sure the young person is included, both they and their parents are happy that all of their needs are met, the young person is safe, has a good time and the parents rest assured that the care is appropriate. Surely this should be the case wherever that young person chooses to go and it is shocking that it isn't - especially when we are talking about services designed for disabled people.

I keep thinking about whether having compassion within a code of practice or training programme will change anything. I work within an organisation where the values of love, justice and forgiveness are entrenched. Our team openly explores what these values mean to us, in term of our relationships with young people, our colleagues and with ourselves. This keeps the values alive and reminds me daily that we are allowed to make and learn from mistakes and that we persevere, and don't give up on young people who don't always turn up. I think these are also close to, if not part of compassion and the only way they support our work is through regular review and discussion, perhaps all we need to do is talk more about what compassion is and why we do the jobs that we do.

The national youth agency has recently released a draft code of ethics for youth work, for professionals joining the Institute for Youth Work, <http://www.iyw.org.uk/join-iyw/code-of-ethics/> Compassion isn't mentioned, however there are two points which I think relates;

---

**share knowledge change lives**

Point 1. In the youth work relationship, the interests of young people have priority. Youth workers do not act against the interests of young people.

and

Point 11. Youth workers equip ourselves with the resources necessary to work effectively with young people and work in a reflective way to monitor our work and develop our abilities. We take account of the impact of our work on ourselves.

This second point is of central importance to me as you must also care about yourself to be able to care for others. The ability to remain compassionate in your work is strengthened by the quality of supervision and support. An organisation must show compassion towards its workers. This is not to say that a worker won't be compassionate without quality supervision, as I'm sure that many are, but they are much more likely to care about their work and understand the impact with good, reflective supervision. It goes beyond managing workload and burn out, if we feel valued for what we do and that people care, we learn to value ourselves and others, including when others don't particularly value us. Effective supervision is based on a basic understanding of the emotional impact of the work and the appropriate challenges; it builds resilience and a sense of achievement that we can all share.

As I mentioned, to begin with, compassion is showing love and kindness, something missing for me in a lot of guidelines and codes of practice; is how we show love, particularly to those who really need it. Looked after children, young people with mental health difficulties, and those experiencing trauma, more than anyone, need to feel a sense of belonging and acceptance. More often than not, these young people are excluded from school, peer groups and society by labels, narrow ideas about behaviour, and a lack of understanding about their issues. We have a responsibility for these young people and the parents who brought them into the world. There have been developments in giving young people more choice and control in decisions that affect their lives, I think that a professional value base that speaks of love and compassion, for all those working with young people, could go a long way to changing attitudes and creating a healthier society.

**Michelle Younger: Chair of careif**

**Senior Project Worker in London at the Children's Society. UK.**

<http://www.childrensociety.org.uk/>

---

**share knowledge change lives**



Centre for Applied Research & Evaluation International Foundation.

[www.careif.org](http://www.careif.org) Twitter @careif email [enquiries@careif.org](mailto:enquiries@careif.org)

## Compassion and Care:

### Perspectives from an Indian Origin Psychologist Working in Danish Academia and Mental Health Services

**Rashmi Singla\* Associate Professor: International Coordinator in Psychology: Department of Psychology and Educational Studies: Roskilde University; Denmark:**

*"I perceive compassion as a key concept in these approaches and practices, Buddhism is the basis of many of them".*

Eastern philosophical, spiritual approaches are gaining increasing popularity in form of mindfulness based applications in Western academia and healthcare as well as in business organisations and other societal institutions. I perceive compassion as a key concept in these approaches and practices, Buddhism is the basis of many of them. In Buddhism, the foundation-stone is the Noble eightfold path that includes the right action being moral and compassionate (Mikulas, 2008). At a higher level the goal of these approaches is enhancing human conditions implying global harmony and well-being. However, an analysis of these meditative practices in the Western context shows that in many applications the concept of compassion and other ethical aspects seem to have been overlooked ( Madsen, 2007, Kabat-Zinn, 2011).

Intermixing and convergence of two different ways of knowing, two epistemologies - the empiricism of Eastern meditative disciplines developed over more than two and half thousand years and the Western post-enlightenment empirical science entails potential benefits as well as perils (Rao et. al, 2008, Singla, 2011,). However, it is important to move beyond the appropriation of Eastern practices in the western context and focus on the positive intermixing, minimising perils. One of the perils is overlooking compassion and perceiving these meditative practices just as techniques.

---

**share knowledge change lives**

What is compassion and what part does it play for mental health professional and care givers like me, a female psychologist who originates from India and has been working with ethnically diverse populations in Denmark for the past three decades?

Compassion is broadly seen as interconnections between people at different levels and from different parts of the world, making it possible to meet people across borders as fellow human beings. This draws on the concept of interdependence of beings compared to the cells of the body being interdependent with all that is around them (Nhat Hanh, 2010).

Zooming in on a relatively pragmatic definition of compassion we invoke Feldman & Kuylen (2011) who have focused explicitly on compassion in mindfulness meditation practice. According to them, compassion is a multi- textured response to pain, sorrow and anguish which includes kindness, empathy, patience, acceptance and equanimity. It is seen as the capacity to perceive, feel and act towards suffering. It implies being open to the reality of suffering, along with an acknowledgement that not all pain can be 'fixed' or 'solved' but all suffering is made more approachable in a landscape of compassion.

Furthermore, Feldman & Kuyken (2011) bring in Neff's definition which includes both *self-compassion* 'being kind and understanding to oneself in instances of pain and failure' and *common humanity* 'perceiving one's experience as part of the larger human experience' in articulation of compassion.

These understandings may sound too idealistic and not pragmatic in these times of late modernity in the Western world, where individualism is a dominating value. However, based on the Buddhist concept of compassion and spirituality from 500 BC as a part of the Noble eight fold path of everyday life, the above conceptualisation includes being kind to oneself as well as perceiving others as fellow human beings.

These understandings have been immensely valuable in my work as a mental health professional as well as a university teacher. Being a visible ethnic minority professional myself, there have been many challenges, struggles – successes as well as failures, where self-compassion has contributed to survival as well thriving. Daily sustained and dedicated meditative practices of spiritual nature have encouraged me to attempt be kind to myself and compassionate to others' suffering in these times of commoditisation, mediatisation, racialisation, neoliberalisation and globalisation of society and social life.

Meditation is a process of 'softening and dissolving of Self, becoming more and more open to Buddha nature (we could say, basic goodness), and a feeling of *growing compassion* for (and

---

**share knowledge change lives**

desire to do something about) the suffering of others' according to Gergen & Hosking (2006). Despite suspicions of these meditative practices emphasising just the well being of the Self, my experiences also indicate that through these practices we realize the limitations and insufficiency of a narrow Self and our profound connection with others.

By raising sensitivity to others' suffering and attempting to alleviate their suffering, the practices have provided possibility of resistance in facing difficulties related to the above mentioned societal processes. Though it is tricky and complicated to evaluate human encounters- professional ones with clients, students, colleagues and more personal ones as a family member, friend, community member - receiving comments such as *warm person, understanding, social trustable* and *supporting* indicate that compassion for me plays a significant part in these relationships and meetings.

Congruently the *common humanity* aspect of compassion has been highly significant in my encounter with people of different ethnicities despite cultural, power and geographical differences. The focus on the commonalities as human beings has contributed to creation of bridges across these differences.

The following simple motto from a psychology professor with Chilean background, in a conference in Tromsø, Norway in 1998 has been extremely salient in my work with people who are apparently different from me: 'We human beings are more similar than different.'

In some instances, it is difficult to be compassionate some health professional and care giver to begin with , e.g. in my encounter with a young criminal boy of Danish background who was a different gender, ethnicity, educational level and activity level – he differed from me in many possible ways. However, I tried to focus on the common humanity and to perceive his experiences as part of the larger human experience, which was a great assistance in the process. Furthermore, Kabat-Zinn's formulation about paying attention to the common potentials of human being, as a professional and a caregiver was also a help in mitigating his difficulties in an enduring way. 'As care-givers, we have to remind ourselves of what we of course already know, namely that all human beings, including ourselves and our patients have, to varying degrees but almost always, far more than we suspect, deep and life-long inner resources for learning, growing, healing and personal transformation.' (Rogers et al, 2013).

At the same time, along with invoking compassion in my professional work, my background as a psychologist using social cultural approach also directs attention to the broader societal, cultural and power aspects related to the clients and students. In order to alleviate others' suffering, one

---

**share knowledge change lives**

must take into account the broader context and not just focus narrowly on the individual. Thus, in an orientation of compassion- empathy, patience and acting towards suffering, inclusion of the broad context is crucial.

Lastly, I would like to emphasise that in application of intervention practices based on Eastern thinking, *inclusion of compassion* consisting of empathy, equanimity and patience towards suffering, along with self-compassion and humanity is beneficial for professionals as well as service users. On a broader level, range of professionals such as nurses, doctors, occupational therapists, psychologists, and social workers in the western countries could benefit by including compassion in their professional practice leading to a *fruitful intermixing* of the Eastern thinking with the Western practices thus contribute to global harmony and well- being.

## References

Feldman, C. & Kuyken, W. (2011) Compassion in the Landscape of Suffering in Williams, J.M & Kabat- Zinn, J. (Eds.) Special issue of *Contemporary Buddhism Mindfulness: Diverse perspectives in its meaning, origin, and multiple applications at the intersection of science and dharma* vol. 12, No.1, 144-155

Gergen, K. & Hosking, D. (2006) If You Meet Social Construction Along The Road: A Dialogue With Buddhism in Merits G.T. Knee, Kenneth J. Green (EDS.) *Horizons in Buddhist Psychology: Practice, Research & Theory* (Featuring a dialogue between the Dalai Lama and Aaron T. Beck). Chagrin Falls, OH: Taos Institute Publications.

Kabat- Zinn J. (2011) Some Reflections on the Origins of MBSR Skillful Means and the Trouble with Maps Contribution to Special Issue of Contemporary Buddhism Volume 11, No. 1.

Madsen, A.D.(2007) *Meditationens fænomenologi: - et filosofisk og psykologisk perspektiv på meditation, Et integreret speciale i fagene Filosofi og Psykologi* (A Masters Dissertation in Disciplins Filosofi & Psychology), Roskilde Universitetscenter, Institut for Psykologi og Uddannelsesforskning.

Mikulas, W. (2008) *Buddhist Psychology: A Western Psychology* in Rao, K.R., Paranjpe A.C. & Dalal, A. C. (2008). *Handbook of Indian Psychology. Pp142-162* New Delhi: Cambridge University Press/Foundation Books Imprint.

*Nhat Hanh, T. (2010) This Sun My Heart* Berkely: Parallax Press

---

**share knowledge change lives**

REGISTERED OFFICE: LARKINS, CORNWALLIS HOUSE, PUDDING LANE, MAIDSTONE, KENT ME14 1NH  
REGISTERED NO. 06231733 ENGLAND CHARITY NO. 1121374

Rao, K. R., Paranjpe A. C. & Dalal, A. C. (Eds) (2008). *Handbook of Indian Psychology*. Pp142-162  
New Delhi: Cambridge University Press/Foundation Books Imprint.

Rogers, B. et al (2013) Mindfulness in Participatory Medicine: Context and Relevance [Reviews](#)  
*Journal of Participatory Medicine* Vol. 5, February.

Singla, R. (2011) Origins of Mindfulness & Meditation: Interplay of Eastern & Western  
Psychology, in *Psyke og Logos*, Vol. 32, Nr. 1 pp 220-239.

\*Rashmi Singla is an Associate Professor, Department of Psychology & Educational Research,  
Roskilde University. She is M.Sc., Delhi University, Cand.Psych. & PhD, University of  
Copenhagen.

PhD. thesis: Youth Relationships and Ethnicity: A Social Psychological Study and Implications for  
Psychosocial Intervention.

Besides researching and teaching in the area of diversity and family relationships, she also has  
extensive experience of practice based psychosocial counselling through her former position as  
clinical Psychologist, Copenhagen Municipality as well as through ongoing engagement in  
N.G.O., Transcultural Therapeutic Team for Ethnic Minority Youth and their families (*T.T.T.*)  
Copenhagen since 1991.

Moreover she has participated in European projects among others, COST project ethnic  
minority and health and has been affiliated to careif, London since 2010. She has published a  
number of books, reports and peer reviewed articles about various psychosocial and  
epistemological aspects relating to movements across borders, recently with focus on couple  
relationships, diasporic identities, transnationalism as well as interplay between Eastern and  
Western psychological understandings.

For publication & professional activities, see link: Web: [www.ruc.dk/~rashmi](http://www.ruc.dk/~rashmi)

**Professor Rashmi Singla. Denmark.**

---

**share knowledge change lives**

REGISTERED OFFICE: LARKINS, CORNWALLIS HOUSE, PUDDING LANE, MAIDSTONE, KENT ME14 1NH  
REGISTERED NO. 06231733 ENGLAND CHARITY NO. 1121374

Centre for Applied Research & Evaluation International Foundation.

[www.careif.org](http://www.careif.org) Twitter @careif email [enquiries@careif.org](mailto:enquiries@careif.org)

## Compassion and Care:

**William Ashdown: careif International Adviser. Canada.  
Vice-President, Mood Disorders Society of Canada:**

*“care and compassion has been limited to those who are ‘attractive’, who are regarded by the public as sympathetic”.*

Seeking care and compassion for the mentally ill is a challenge on many levels. So much of what is expressed is subject to the biases and viewpoints of the public, with results that can be disturbing. Take two recent cases from my own home city of Winnipeg.

Two cases of murder have shocked the city’s inhabitants deeply, and created a firestorm of media attention and public outrage. Each was committed by a person in the throes of a clearly defined and identifiable mental illness; schizophrenia, on the one hand, and post partum psychosis on the other. Each of the perpetrators was known to health authorities as having been seriously ill and in crisis. Despite the obvious severity of their illnesses, both were released from care and were allowed to leave the medical system, one quite involuntarily.

One was a middle aged Chinese man, an immigrant, who spoke little English, was estranged from his family, and who was travelling across Canada in a Greyhound bus, apparently in a delusional state. Outside of Winnipeg and for no apparent reason, he attacked another man on the bus, with no warning. There had been no interaction between them prior to the attack. The assault was carried out by a long hunting knife, and resulted in the decapitation of the victim. The bus driver was able to halt the vehicle and remove all the other passengers, leaving the attacker to race up and down the aisle, swinging the head of his victim, while consuming some of the victim’s flesh. He was finally taken into custody by the RCMP.

The other murderer was a young mother in her twenties, who apparently drowned her two children, both under two years of age, in a bathtub, while suffering from an acute episode of post-partum psychosis, for which she had already been diagnosed. She then called emergency

---

**share knowledge change lives**

REGISTERED OFFICE: LARKINS, CORNWALLIS HOUSE, PUDDING LANE, MAIDSTONE, KENT ME14 1NH  
REGISTERED NO. 06231733 ENGLAND CHARITY NO. 1121374

services, and disappeared from the house. Her body was later recovered a few days later, drowned in a nearby river.

The family was white, middle class and lived in an affluent neighbourhood, with lots of available supports, most of whom were completely ignorant of the severity of her illness.

What made these cases so notable was the difference in the level of public reaction. Both attracted enormous national attention, dominating the news for many days. Despite the fact that mental illness had clearly played a major role in each case, very few commentators noted the similarities.

Instead, the first case resulted in calls by tens of thousands of citizens for much harsher punishments for the murderer. The case was followed in excruciating detail, and was the grist of talk shows for months. Every small change was seized upon by the public for more debate. Despite being found “Not Guilty by Reason of Mental Defect or Disorder”, overwhelmingly, the public called for much harsher and extreme measures, regardless of the fact that the normal protocols for mentally ill criminals had been followed carefully. Much of it was clearly racist. Endless public debate took place on creating further and more severe punishments, from lifetime solitary confinement, to immediate execution. Papers across Canada seized on the trial as a call for tougher measures against violent crime. Little attention was paid to the illness behind the case.

The other murderer was a young, pretty, blonde mother, who was married, with a handsome husband and two attractive children. They lived in a prosperous middle class neighbourhood, and seemed to be surrounded by friends and family. They were the very image of a ‘good’ family’. After the deaths of her two children were discovered, large public memorials and demonstrations were held for her and her children. Hundreds of strangers came out to honour both the victims and the perpetrator. The focus was not on the perpetrator, but on the illnesses that drove her to her crimes. She was seen as a victim of her own illness, with enormous sympathy towards the father and remaining family. A huge, very public funeral was held for all three, with editorials both locally and nationally for improved services for the mentally ill.

The cases shared many similarities: Both were severely mentally ill. Both had been in care and had been released while clearly unwell. Both had apparently been severely delusional. And both murderers committed deliberate murder, driven by their illnesses.

However, it was the differences in the cases that set them apart in the public eye: Large public memorials were held for the young mother and her two children involving hundreds of

---

**share knowledge change lives**

strangers, who came out to honour the victims and the perpetrator. Great sympathy was seen towards the father and remaining family, with huge, very public funerals for all three. Much public outcry against resource shortages, demands for stronger resources, less stigma, more outreach. Pledges of financial support were received, both for the family and for the illness of postpartum psychosis.

In the other case, the victim alone was celebrated through a large public funeral and display of grief. However, the perpetrator's own family was completely ignored. Talk shows across the country repeatedly vilified him as a monster, with demands for much stronger incarceration, much harsher punishment. Letters were written and petitions started to demand political action to punish him more harshly, and create more protection against the mentally ill. Some went so far as to demand the immediate incarceration of all seriously mentally ill, as a protective measure. Much of these comments and actions came with racial undertones. Few calls were heard for increased research or education into schizophrenia.

This has demonstrated stark differences in public attitudes: the knife-wielding foreign monster versus the poor deluded victim. Two very similar tragedies, with totally different outcomes. There has been little or no care towards the mentally ill murderer: no compassion, no sympathy, massive disapproval, and the exposure of cruel public attitudes. All the care and compassion has been limited to those who are 'attractive', who are regarded by the public as sympathetic.

**William Ashdown: careif International Adviser. Canada.**  
**Vice-President, Mood Disorders Society of Canada**  
[www.mooddorderscanada.ca](http://www.mooddorderscanada.ca)

---

**share knowledge change lives**

REGISTERED OFFICE: LARKINS, CORNWALLIS HOUSE, PUDDING LANE, MAIDSTONE, KENT ME14 1NH  
REGISTERED NO. 06231733 ENGLAND CHARITY NO. 1121374



Centre for Applied Research & Evaluation International Foundation.

[www.careif.org](http://www.careif.org) Twitter @careif email [enquiries@careif.org](mailto:enquiries@careif.org)

## Compassion and Care:

### Compassion and Health; Headlines for the Right Reasons

**Yasmin Khatib: careif Volunteer:**

**Lecturer at The Centre for Psychiatry, Barts and The London School of Medicine and Dentistry, Queen Mary, University of London. UK:**

*“It’s time for each individual involved in the delivery of care to reflect on how their behaviour can have a profound and sometimes life changing effect on each patient”.*

#### Incidents of Neglect

Compassion and care – these words have made headlines recently and unfortunately, not for the right reasons. Alarming stories have emerged regarding the use, or the misuse, of The Liverpool Care Pathway for the Dying, often abbreviated to The Liverpool Care Pathway (LCP). Where an independent review into the LCP revealed that amongst numerous shocking incidents and failings of care, some patients spent their final hours distressed and thirsty and family members who tried to provide their loved ones with a drink of water were shouted not to do so by nurses ‘managing’ the patients.

Patients spent their final hours distressed and thirsty and family members who tried to provide their loved ones with a drink of water were shouted not to do so by nurses ‘managing’ the patients.

---

**share knowledge change lives**

Unfortunately, these aren't isolated incidents of neglect. An independent inquiry into care provided by mid Staffordshire National Health Service (NHS) Foundation Trust revealed appalling accounts of neglect leading to between 400 and 1200 deaths over a 4 year span.

### **What went wrong?**

So what do we know about these acts of substandard and abusive care? How, can we reconcile neglect of patients during the LCP when the pathway was originally developed as a way of helping patients as they approach their end of life care? That the intention of the LCP was to provide a framework for a multidisciplinary team of professionals to adopt a hospice model of care, so that the patient's physical, social, spiritual and psychological needs were considered as part of their care to make the end of their life as comfortable as possible. Ironically, before these justified complaints were made, the LCP was considered a model of good practice to support end of life care by successive national policy frameworks and the National Institute for Clinical Excellence, (NICE) – now the National Institute for Health and Care Excellence - quality standard for end of life care for adults. So what went wrong? Was there a collective level of extreme incompetence from the staff involved in the delivery of care? Had healthcare staff developed compassion fatigue, or emotionally hardened over-time? Did the staff involved ever develop a sufficient level of compassion in the first place? Or are these events reflecting wider societal challenges in the flow of affect, in particular the role of compassion?

As expected, the Mid Staffordshire Inquiry identified numerous warning signs leading to the development of problems at the Trust, but interestingly several of these warnings could be applied to many environments where standards aren't being met. For example, the Inquiry identified that 'assumptions that monitoring, performance management or intervention was the responsibility of someone else' and that there was a 'failure to tackle challenges to the building of a positive culture' in addition to the breakdown of communication and 'a culture focused on doing the system's business – not that of the patients'. The misuse of the LCP and neglect in the Mid Staffordshire Trust have highlighted the dangers of tick box mentality, where care was solely a task of 'doing the system's business'. The essence of what patients actually need was possibly never a consideration in the first place. Perhaps these underlying problems need to be understood through the lens of compassion. Compassion has been defined as a

---

**share knowledge change lives**

deep awareness of the suffering of another coupled with the wish to relieve it. Interestingly though, self-compassion isn't included as a facet within this definition.

### **The Way Forward**

After identifying factors that shed light on what might have gone wrong, it's also essential to ask ourselves what's the way forward from this? Medical education has identified that clinical competence encompasses cognitive and applied aspects of knowledge, skills and attitudes. All well and good, but at times when waiting lists are long and staff shortages are pushing healthcare professionals above and beyond their physical and emotional limits, what's an achievable way forward to ensure that the appropriate people have skills to deliver competent and compassionate care to the highest standard possible? There is no clear cut solution to this problem, but maybe it's time to review how doctors and the allied healthcare professionals are trained to deal with delivering care to patients. Another possibility might include the introduction of a Physician Assistants, as used in the USA to work alongside doctors in an attempt to provide high quality patient care. Or maybe it's time for each individual involved in the delivery of care to reflect on how their behaviour can have a profound and sometimes life changing effect on each patient that they interact with.

**Yasmin Khatib** is a Lecturer at The Centre for Psychiatry, Barts and The London School of Medicine and Dentistry, Queen Mary, University of London. Yasmin is a lecturer and tutor on the MSc in Mental Health, which includes MSc pathways in Psychological Therapies and Transcultural Mental Health. Yasmin is also the pathway manager for a new MSc in Mental Health and Law, a jointly led MSc between Barts and The London School of Medicine and Dentistry and The Department of Law at Queen Mary, University of London - [www.qmul.ac.uk/mentalhealth](http://www.qmul.ac.uk/mentalhealth)

Yasmin's area of research expertise is in transcultural mental health, psychiatric epidemiology, young people's mental health and medical education. Yasmin has presented her work at national and international academic conferences and she is also a volunteer for the international charity careif.

**Yasmin Khatib: careif Volunteer:**

**Lecturer at The Centre for Psychiatry, Barts and The London School of Medicine and Dentistry, Queen Mary, University of London. UK.**

---

**share knowledge change lives**

**Centre for Applied Research & Evaluation International Foundation.**

[www.careif.org](http://www.careif.org) Twitter [@careif](https://twitter.com/careif) email [enquiries@careif.org](mailto:enquiries@careif.org)

## **Compassion and Care**

**Anil Thapliyal: - careif International Advisor: New Zealand  
CEO, HealthTRx Limited: New Zealand:**

*“a place where my suffering and its alleviation can inform yours”.*

Mental health is trendy.

Not in the ‘cool and hip’ sense, though most of our coolest and hippest people have known mental distress.

Rather, mental health goes through trends. How we understand the extremes of our human experience and how we formulate responses to those experiences are like waves that peak and trough in popularity. Paradigms rise and fall with the tides of evidence-based approaches and best practice, all the while reminding us that there is little new under the Sun.

As the recent recovery tsunami reaches saturation point, flooding clinical and non-clinical services, the latest swell arriving on our shores is peer support. It’s a simple idea – that people with a lived experience of mental illness and addiction can help others with a similar lived experience.

More than ‘can help’ the proponents would argue, but rather ‘do help’, ‘always have helped’, ‘are the best at helping’ and ‘should have a primary role in helping’.

It’s easy to pin point to historical precedents, such as the 19<sup>th</sup> century Alleged Lunatics' Friend Society and founding of Alcoholics Anonymous in 1935, but the underpinning idea goes much deeper with the archetype of the Wounded Healer.

---

**share knowledge change lives**

REGISTERED OFFICE: LARKINS, CORNWALLIS HOUSE, PUDDING LANE, MAIDSTONE, KENT ME14 1NH  
REGISTERED NO. 06231733 ENGLAND CHARITY NO. 1121374

Its re-emergence and rise to popularity is a timely reminder of the importance of compassion in a mental health care system focussed on outputs and outcomes, where procedure trumps practice and key performance indicators eclipse human responsiveness.

Compassion is at the heart of caring, and is an implicit imperative of the peer support philosophy. Simply put, compassion is 'fellow feeling' (OED) with a related desire to help:

“Sympathetic consciousness of others' distress together with a desire to alleviate it”

Merriam-Webster Dictionary

To have compassion then is to have an understanding and appreciation of another's suffering or distress.

How often in our clinical training and practice are we encouraged to avoid that very understanding? To purposefully construct barriers to such an appreciation?

We train our staff to keep a psychological distance and not engage beyond symptoms and treatment. Our policies and procedures have become designed to mechanise our natural altruism and concern. Much of our own 'self-care' practices have become focussed on 'protecting' ourselves from our own feelings and quickly processing any emotional response through debrief and supervision.

We have become experts in delivering human services without humanity.

Peer support provides both a direct challenge to this and an alternative philosophy and practice. It embraces our humaneness, that we are unique and unified by our shared experiences, and builds a range of effective approaches to using that humaneness in helping others. In doing so, it also gives everyone of us the option to take a step beyond sympathy and into empathy – a place where my suffering and its alleviation can inform yours.

By cultivating compassion peer support opens the door for authentic caring.

**Anil Thapliyal: - careif International Advisor – New Zealand.  
CEO, HealthTRx Limited - New Zealand.**

---

**share knowledge change lives**

REGISTERED OFFICE: LARKINS, CORNWALLIS HOUSE, PUDDING LANE, MAIDSTONE, KENT ME14 1NH  
REGISTERED NO. 06231733 ENGLAND CHARITY NO. 1121374

Centre for Applied Research & Evaluation International Foundation.

[www.careif.org](http://www.careif.org) Twitter @careif email [enquiries@careif.org](mailto:enquiries@careif.org)

## Compassion and Care

### RELIGION, SPIRITUALITY AND COMPASSION: IMPLICATIONS FOR CLINICAL PRACTICE

Simon Dein: **Professor Cultural Psychiatry & Consultant Psychiatrist: UK.**

*“physicians have attempted to balance their care by going back to medicine's more spiritual roots, recognizing that until modern times spirituality has often played a significant part in health care”.*

2 Corinthians 1:3-7 *"Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves received from God.*

The technological advances of the past century have changed the focus of medicine from a caring, service oriented model to a technological model which emphasises cure ( Pulchalski 2001). Without doubt this technology has led to great advances in medicine and has given us the ability to prolong life.

However, in the past few decades ‘physicians have attempted to balance their care by going back to medicine's more spiritual roots, recognizing that until modern times, spirituality has often played a significant part in health care.

The etymology of the term "compassion" is Latin, meaning "co-suffering." More involved than simple [empathy](#), compassion commonly gives rise to an active [desire](#) to alleviate another's

---

**share knowledge change lives**

suffering. The concept is widespread in the world's religions. The word *compassion* means "to suffer with." Compassionate care calls physicians to walk with people in the midst of their pain, to be partners with patients rather than experts dictating information to them.

The study of compassion is an important element of the emerging field of positive psychology. Compassion is viewed as an emotion that is essential in helping professions (Cassell 2009). It involves the ability to identify with another person and has been found to comprise three requisites:

People must feel that troubles that evoke their feelings are serious,  
People require that sufferers' troubles are not self-inflicted, and that  
People must be able to picture themselves with the same problems.

It is related to the term empathy. *Empathy* is defined as the ability to understand the patient's situation, perspective, and feelings and to communicate back that understanding. However empathy lacks an internal motive to do something and is, instead, a technical ability.

This is an important difference in these two concepts, which in many other ways are merely different ways to describe a wide spectrum of emotional experience.

Within clinical practice compassion is essential as part of patient care. Physicians who utilise compassion understand the effects of sickness and suffering on human behavior (Cassell 1985). However there has been much concern by those in today's medical practice both in the UK and in the USA that it has become highly bureaucracy and business like, driven by financial and efficiency issues and lacks humanistic values.

What has happened to compassion? While professionalism and empathy are commonly mentioned in the medical literature, compassion is not.

Why is this?

Could it be that health professionals fear compassion fatigue?

Does it interfere with rational reasoning?

There is no evidence to support these two assertions. Rather there has also been evidence suggesting that compassion helps counter a variety of negative emotion (Lutz et al 2004), thus there is an obvious argument for developing compassion.

How this could be done should be a focus for future research.

---

**share knowledge change lives**

## References:

Cassell, Eric (1985). *The Nature of Suffering*. New York: Oxford University Press  
Cassell, Eric (2009). *Oxford Handbook of Positive Psychology* (2 ed.). New York, New York: Oxford University Press. pp. 393–403.

Lutz A, Greischar LL, Rawlings NB, Ricard M, Davidson RJ. Long-term meditators self-induce high-amplitude gamma synchrony during mental practice. *Proc Natl Acad Sci USA*. 2004;101:16369–16373 bringing calmness to a physician's practice.

Pulchalski CM. The role of spirituality in health care. *BUMC Proceeding*. 2001;14:352–357.

**Simon Dein: Professor of Cultural Psychiatry & Consultant Psychiatrist: UK.**

**Centre for Applied Research & Evaluation International Foundation.**

[www.careif.org](http://www.careif.org) Twitter [@careif](https://twitter.com/careif) email [enquiries@careif.org](mailto:enquiries@careif.org)

---

**share knowledge change lives**

REGISTERED OFFICE: LARKINS, CORNWALLIS HOUSE, PUDDING LANE, MAIDSTONE, KENT ME14 1NH  
REGISTERED NO. 06231733 ENGLAND CHARITY NO. 1121374